

V S S L

# **Paying for and Delivering Telehealth in the Covid Era: Early Groundwork in WA Medicaid**

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**Prepared by:**

The Value & Systems Science Lab  
University of Washington School of Medicine  
1959 NE Pacific Street  
Seattle, WA 98195

**In Collaboration with:**

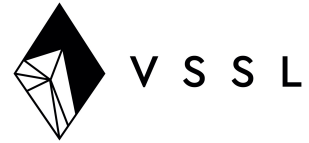
Washington State Health Care Authority  
626 8th Ave SE  
Olympia, WA 98501

## **Executive Summary**

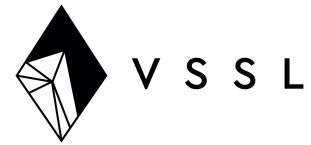
Covid-19 has created immense health care disruption in Washington state and beyond. Like others across the country, providers and payers in Washington responded to these pressures by turning toward telehealth. To promote these changes and create flexibility, national and local payers relaxed telemedicine and telehealth requirements.

The Washington State Health Care Authority (HCA) made this transition in WA Medicaid by building upon established telehealth policies. This work included policies related to payment parity, primary and specialty care coordination, and the use of telehealth for specific types of care and the care of specific populations. To complement these policies, HCA also made direct patient- and provider-oriented investments in telehealth-related technology and focused on clinical implementation. Collectively, these policy changes, technology investments, and implementation support efforts drove significant adoption of telehealth in the early phase of the pandemic. They also represent early groundwork for a broader telehealth payment and care delivery policy agenda for WA Medicaid.

This agenda is needed because questions remain about how to best implement telehealth in WA Medicaid beyond the early stages of the pandemic. For instance, more work is needed to understand the policy and care delivery implications of the timing of telehealth implementation; the use of telehealth in different care settings; the role of service type and organizational factors on the use and impact of telehealth.



Future directions could include work focused on a series of questions, including the relationship between telehealth and health care access, quality, and spending; the effect of telehealth on health care equity and disparities; the potential impact of expanded telehealth on existing and future care delivery models; and the payment strategies and models can promote telehealth while mitigating unintended consequences. To pursue this work, the HCA will need to identify current evidence, knowledge gaps requiring additional research, and potential policy levers for effectively codifying telehealth in ways that ultimately improve care.



## **The Impact of Covid-19 on Health Care and Investment in Telehealth**

1.A. Covid-19 has created immense health care disruption in Washington state and beyond. When SARS-CoV-2 initially emerged, patients around the country delayed or avoided care due to fear of contracting infection. Hospitals and clinics stopped elective procedures, deferred non-critical imaging exams, and cancelled non-essential office visits. Behind these forces, patient volumes plummeted nearly 60% in some areas, forcing many providers to reduce their workforce and implement other cost-cutting measures.<sup>1,2</sup> These changes have led to major financial strain on providers such as primary care practices and hospitals.<sup>3,4</sup>

1.B. Like others across the country, providers and payers in Washington responded to these pressures by turning toward telehealth. Clinicians and practices swapped in-person visits for virtual encounters (either telephone or via video visits) with patients with both Covid and non-Covid needs. In some areas, these changes lead to dramatic increases in telemedicine visits by nearly 15% through mid-April.<sup>1</sup>

To promote these changes and create flexibility, national and local payers relaxed telemedicine and telehealth (see *Spotlight*) requirements. The Centers for Medicare and Medicaid Services (CMS) greatly expanded the services that could be furnished via telehealth while ensuring payment parity between in-person and tele-services.<sup>5</sup> Washington state instituted similar provisions for commercial carriers via Senate Bill 5385.<sup>6</sup> CMS has already expressed interest in maintaining expanded telehealth capabilities going forward beyond the pandemic.<sup>7</sup>

## Spotlight: Telemedicine versus Telehealth

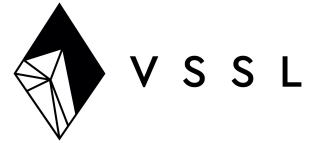


While the two terms can be and often are used interchangeably, some use *telemedicine* to refer the use of technology to support the delivery of clinical patient care services between different locations. In contrast, some use *telehealth* as a more encompassing term that also includes other services (e.g., public health related) alongside clinical services.

Given its broader scope, telehealth is not necessarily bound by all the requirements involved in telemedicine. For instance, the HCA defines telemedicine as “a form of telehealth that supports the delivery of health care services” that does not include certain mechanisms (audio-only telephone, facsimile, and email mechanisms).<sup>8</sup>

Moreover, the Washington State Legislature defines telemedicine as follows: “when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward technology to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located. If the service is provided through store and forward technology, there must be an associated office visit between the client and the referring health care provider.”<sup>9</sup>

In contrast, the HCA defines telehealth as “the use of electronic information and telecommunications technologies to support distant primary health and behavioral health care; patient and



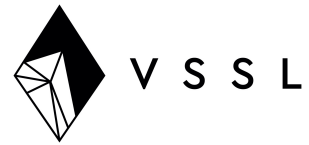
professional health-related education; public health, and health administration. HCA is using telehealth modalities to provide assessment, diagnosis, intervention, consultation, supervision and information in lieu of an in-person visit.”<sup>8</sup> Telehealth includes non-HIPAA compliant, real-time audio or video services, as well as other modalities such as patient portal visits or audio-only services that would not fall under telemedicine.

This report focuses on telehealth as a more encompassing term, acknowledging the Covid-related decision from the US Department of Health and Human Services Office of Civil Rights to avoid imposing penalties for non-compliance with regulations governed by HIPAA rules.

## **2. Early Groundwork in WA Medicaid to Transform Care via Telehealth**

2.A. The Washington State Health Care Authority (HCA) made this transition by building upon established telehealth policies in the WA Medicaid program. HCA has implemented a series of telehealth policies<sup>10</sup> for Medicaid beneficiaries and worked in concert with its managed care organizations (MCOs) that matching, coordinated policies were either in place or newly implemented for managed care patients.

*2.A.1. Payment Parity.* Even prior to the pandemic, WA Medicaid had established payment parity between in-person and real-time audio-video telemedicine services. This policy served as a foundation that sped the HCA’s expansion of payment parity to other types of telehealth, including (a) audio only and (b) non-HIPAA compliant real-time audio-video care,



the latter of which was enabled by the US Department of Health and Human Services Office of Civil Rights exercising its enforcement discretion (i.e., not imposing penalties for non-compliance with regulations governed by HIPAA rules).<sup>11</sup>

*2.A.2. Primary & Specialty Care Coordination.* WA Medicaid acted quickly to implement policies that enabled clinicians to maintain health care access and quality via telehealth. In particular, the HCA covered a set of services – including (a) interprofessional consults (i.e., “eConsults”), patient portal-based visits, and virtual check-ins – that enabled patients to receive coordinated primary and specialty care.

*2.A.3. Specific Populations and Service Types.* For instance, in concert with the Washington Chapter of the American Association of Pediatrics, the HCA developed a policy that would enable pediatricians to continue conducting well-child visits via telemedicine, recognizing the fact that certain components of the physical exam would not be able to be conducted in person and would need to be completed at a later date. As another example, the HCA expanded the dental, physical therapy, and occupational therapy services that could be provided via telehealth modalities.

2.B. To complement these policies, HCA also made direct investments in telehealth-related technology. The HCA recognized that the “digital divide” (see *Spotlight*) would limit the ability for Medicaid patients and some of their clinicians to use telehealth effectively. In response, the HCA made several investments to support telehealth transformation:

*2.B.1. Clinician-Oriented Investments.* The HCA procured a number of Zoom licenses and directly provisioned them to safety-net providers that lacked sufficient infrastructure to support their own telehealth platforms. These licenses allowed providers to provide care to patients in a HIPAA-compliant manner via real-time audio/video.<sup>12</sup>

*2.B.2. Patient-Oriented Investments.* The HCA directly provisioned cell phones to 6,000 Medicaid patients, including children, tribal members, Health Home clients, and patients receiving care from behavioral health providers, the elderly (via the Area Agencies on Aging), and homeless individuals (via the Foundational Community Supports program). HCA also had conversations with the WA Office of Broadband to identify areas in which connectivity and broadband access could be improved.

### **Spotlight: Digital Divide**



As a concept, the digital divide can be defined as an uneven distribution across individuals or groups with respect to access, use, or impact of information and communication technologies.<sup>13,14</sup>

The divide can occur along multiple dimensions, including geography and social factors.

The digital divide may pose implications for access, quality, and outcomes in health care. For instance, one study evaluated the use of patient portals – online platforms through which patients can communicate with their care team, see results, and view their electronic



health record – among 842 patients admitted to 6 hospitals in the Midwest.<sup>15</sup> The study found that older patients (age 60 or older) were less likely to utilize inpatient patient portals than younger patients (age 18-29), and that African American patients also used the portal less than White patients (40.4% difference).

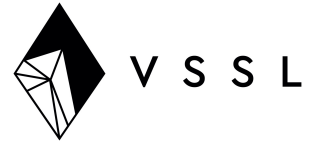
2.C. The HCA also focused on telehealth education and implementation. To educate clinicians and practices on new telehealth policies, WA Medicaid held webinars for clinicians providing behavioral health, medical, and dental services. For instance, the HCA worked with partners in the state to support training and deployment of telehealth services for behavioral health services (see *Spotlight*).

### **Spotlight: BHI Telehealth Rapid Response Initiative**



The HCA partnered with the Behavioral Health Institute (BHI) at the University of Washington, as well as managed care organizations, and other groups in the state on The BHI Telehealth Rapid Response Initiative. The goal of the initiative is to support rapid implementation of telehealth through training and technical assistance related to issues such as workflows, clinical supervision, and procedure development.<sup>16</sup>

The HCA's work in this area leveraged ongoing work with the Behavioral Health Training, Workforce and



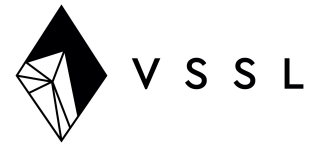
Policy Center (BHTWPC) of the BHI to develop a statewide behavioral health training proposal.<sup>17</sup>

2.D. Collectively, these policy changes, technology investments, and educational and implementation efforts drove significant adoption of telehealth in the early phase of the pandemic. Among its five Medicaid MCOs, HCA saw telehealth utilization increase in some plans by >20-fold from pre-pandemic levels between (February 2020) and (May 2020). Increased utilization occurred for both physical and behavioral health services.

2.E. Despite these measures, additional questions remain about how to best implement telehealth in WA Medicaid, and how it will impact patients, beyond the early stages of the pandemic. WA Medicaid and other stakeholders must consider the optimal ways to implement telehealth going forward. Several factors to consider:

*2.E.1. Timeline.* The rationale for telehealth investment is straightforward amid acute pandemic conditions: there are few alternatives to virtual and phone-based care when in-person contact is heavily restricted and usual operational models are severely disrupted.

However, as the state transitions to a continuing phase in which in-person care is reinitiated alongside ongoing surveillance and control of periodic spikes in viral transmission. In this phase, providers must choose between codifying less familiar (and therefore, likely riskier) telehealth-based delivery models versus more familiar, prior ones. As clinicians and patients are again to choose between in-person or tele-visits, stakeholders need clear understanding of the true



advantages and disadvantages of telehealth compared to in-person care.

*2.E.2. Care Setting.* One emerging lesson from Covid-19 is the opportunity to reconsider how and where to deliver care to patients. Telehealth could provide more flexibility in care setting (e.g., services that required in-person visits could be delivered to patients in their own homes). More work is needed to understand the policy and care delivery implications of using telehealth in different settings or using telehealth to shift the setting in which care is delivered.

*2.E.3. Service Type.* Like other policymakers and payers, the HCA must consider how to use policy to ensure that telehealth and telemedicine are improving rather than harming care. Telehealth is an umbrella term that encompasses multiple health care and non-health care services, and some may merit more investment than others. Similarly, though telemedicine represents a more focused set of health care services, teleplatforms may be more effective for some services than others. More work is needed to consider these factors in understanding the use and impact telehealth among Medicaid populations.

*2.E.4. Organizational Setting and Structure.* Telemedicine and telehealth services are not delivered to patients in a vacuum. Instead, their effectiveness and feasibility can depend on organizational settings and structures in which they are implemented. For instance, telehealth could present challenges in certain settings (e.g., rural versus urban) and under certain structures (small single-specialty practices versus large multispecialty practices; stand-alone practices vs practices within an integrated delivery system). Organizations that

possess telehealth and telemedicine capabilities may differ from those that do not (see *Spotlight*), and certain organizational structures can present telehealth implementation barriers or facilitators. More work is needed to consider how these factors can affect the use or impact of telehealth among Medicaid populations.

### **Spotlight: Telemedicine Availability Among US Hospitals**

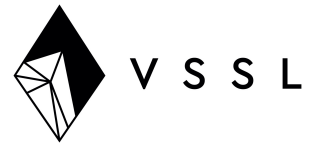


In a cross-sectional study of data from the American Hospital Association, researchers evaluated the availability of telemedicine services across approximately 4,400 hospitals.<sup>18</sup> Nearly half (47.6%) reported providing telehealth-based consultation and office visit services. Compared to hospitals that did not possess those services, those that did tended to be large, not-for-profit, private teaching hospitals.

In addition to highlighting differences in organizational characteristics, the study also demonstrated large variation across states with respect to the proportion of hospitals that possessed telehealth-based consultation and office visit services. Washington state ranked #22 among states/territories with respect to that measure.

### **3. Future Directions for a Payment and Delivery Policy Agenda**

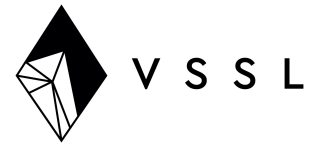
As evidenced across the nation and within WA Medicaid, Covid-19 has clearly begun to accelerate adoption of and transformation in



telehealth. However, the real opportunities and challenges in this shift will emerge not in the earliest phases of the pandemic, but going forward as it extends and ultimately recedes. Given these stakes, a number of outstanding payment and delivery policy questions remain, including:

- What is the relationship between telehealth and health care access, quality, and spending?
  - How do these effects vary by specific service type and patient population?
  - How do these effects vary between primary care, mental health, and different types of specialty care?
- What is the effect of telehealth on health care equity and disparities?
- What is the potential impact of expanded telehealth on existing and future care delivery models?
- What are the payment implications of broader telehealth adoption?
- What payment strategies and models can promote telehealth while mitigating unintended consequences?

To address these types of topics, HCA will need to identify (a) current evidence, (b) knowledge gaps requiring additional research, (c) and potential policy levers for effectively codifying telehealth in ways that ultimately improve care. This work could include data analysis that seeks to understand:

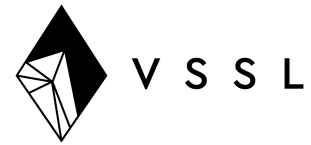


- Telehealth utilization by patient characteristics:
  - Clinical (e.g., clinical complexity, frailty, co-morbidities)
  - Social (e.g., socioeconomic factors)
  - Community (e.g., urban/rural location, area-level determinants)
- Telehealth utilization by provider characteristics
  - Organizational Setting
  - Organizational Structure
- Telehealth utilization by safety-net vs non-safety-net providers
- Disparities in use and impact of telehealth

#### **4. Conclusion**

As part of its response to the early phase of Covid-19, the Health Care Authority (HCA) built upon established payment and care delivery policies to implement telehealth in WA Medicaid. Collectively, these efforts drove significant adoption of telehealth and represent early groundwork for a broader telehealth payment and care delivery policy agenda that could be established for WA Medicaid.

To support such an agenda, future directions could include future work addressing questions about how to best implement telehealth in WA Medicaid beyond the early stages of the pandemic. Doing so will likely involve identifying current evidence, knowledge gaps requiring

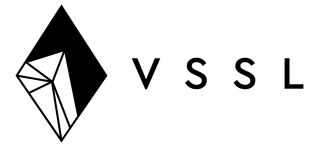


additional research, and potential policy levers for effectively codifying telehealth in ways that ultimately improve care.

**Note:** This work does not provide legal or compliance advice or guidance and should not be construed as such. When applying policies and services to patients, healthcare professionals and other readers are advised to consult policy documents directly to verify, among other things, conditions of use, particularly if the policies or services being applied to patients are new, infrequently used, and involve multiple requirements. VSSL and its authors disclaim any and all warranties, express or implied, about this work and assume no responsibility for any injury and/or damage to persons or property, as a matter of products liability, negligence law or otherwise, or from any reference to or use by any person of this work.

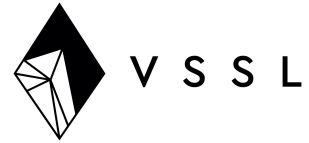
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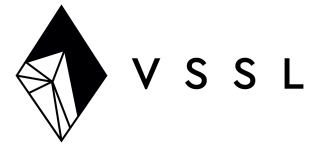


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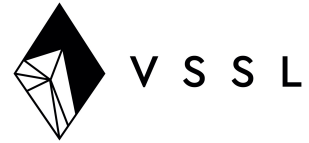




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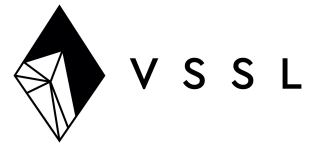


## The Value & Systems Science Lab

Situated at the University of Washington (UW) within the UW School of Medicine and the UW Medicine Center for Scholarship in Patient Care Quality and Safety, the Value & Systems Science Lab (“The Lab”) is designed to use (a) policy analysis, (b) program evaluation, and (c) implementation strategy to support change that impacts patients and populations.

VSSL possesses content expertise in health policy, care delivery redesign, and decision sciences, as well as leadership experience in population health, value-based purchasing and care delivery. The Lab leverages this deep expertise into work that spans technical policy analysis, strategy advising, and analyses ranging from small pilots to large, externally grant-funded evaluations. VSSL members contributing to this report:

Joshua M. Liao, MD, MSc. Dr. Liao is a practicing internal medicine physician and faculty in the UW School of Medicine and School of Public Health. He is a national expert in health care payment and delivery policy, advising public and private policymakers on payment and delivery issues, as well as serving as an advisor to the RVS Update Committee (RUC) – a group that provides recommendations to Medicare on how to value physician work when setting payment rates. Dr. Liao trained in internal medicine at the Brigham & Women’s Hospital, where he was a Clinical Fellow in Medicine at Harvard Medical School. He obtained his policy analysis and research training from the University of Pennsylvania, where he is an Adjunct Senior Fellow at the Leonard Davis Institute of Health Economics.



Ashok Reddy, MD, MSc. Dr. Reddy is a founding member of VSSL. He is a primary care physician, Assistant Professor at UW, and the Associate director of the VA's national Primary Care Analytics Team. Dr. Reddy has focused his career on evaluations and implementation of reforms in primary care at both the state and federal levels. He served as senior advisor for the Center for Medicare and Medicaid Innovation Center's Comprehensive Primary Care Plus. Dr. Reddy trained in internal medicine at the UW School of Medicine and obtained his policy analysis and research training from the University of Pennsylvania as a Robert Wood Johnson Clinical Scholar.

Learn more about VSSL by visiting the [Lab website](#).